PracSavvy

Clinical Systems Support and Training

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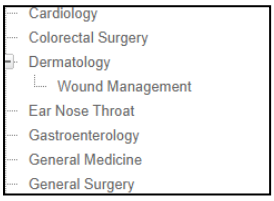
December 2022 — Newsbrief

Welcome to this month's newsletter and happy December to everyone (seems like a safe thing to say!) There is plenty to talk about this month and plenty to be cheerful about, especially if you are a GP in the north of the state. In fact there are 30 reasons to be cheerful, given that there are now 30 referral points at the LGH that are now electronically referrable via your Healthlink Smartforms. In a further effort to inspire you, I'm going to show you all of them.



As you see an absolute cornucopia of possibilities for ereferral to what PHT somewhat unusually refers to as *non-GP Medical Specialists.* Maybe, I'm just not familiar with the term, or maybe I'm *Intellectually Diverse.* Anyway, see page 3 for some tips on using these referral forms.

The other hot topic of course has been around the shortage of GPs with the claim being made that only 14% of medical graduates want to go into General Practice, down from 60% a decade or so ago. The usual justifiable claims have been made, but I can't help wondering if widening the thinking might be beneficial. So in the hope of provoking thought and hopefully not too much anger..

Medicare Rebate: Told it's disappointingly low, no reason to think otherwise. Despite this, around 68% of GPs nationally are able to work part time, as opposed to around 30% of workers across all ocupations. Admittedly the median response to hours worked for part time GPs was 35 hours per week, so just a little less than full time.

Pharmacists: Should we really be worried about pharmacists providing flu vaccinations etc whilst acknowledging that GPs can't currently meet patient demand?

Appointments: I've heard a few stories lately about quite stressed and sick people being told that they couldn't have an appointment with their GP for several weeks. When I hear this, I always wonder how many people who aren't actually sick, but rather attending for a care plan review or health assessment etc are being seen ahead of genuinely unwell people. Are practices leaving enough space in their books for the suddenly unwell? Possibly they are, possibly only some are, I wonder about this. A question I have asked GPs on 2 occasions, and mean to ask more is, "What percentage of people that you saw today, really needed to see a doctor?". Both times the percentage was very very low.

Item Numbers: Many practices top up their funding by utilising Care Plan and Health assessment Item numbers. As far as I recall the Care Plan 721 number came in about 15 years ago, and it and associated Item numbers represented an effort to reduce hospitalisations due to worsening chronic disease and general health conditions. Has this "ounce of prevention" actually worked? Does anybody know and is it even measurable? Public Hospitals seem to be constantly running at 99%, and possibly always will be. Is it time to start incentivising appointment availability at practices? Is keeping people out of DEM today a more achievable goal than keeping people out of hospital in the long term? Is an appointment because you are unwell a more potent episode of care than a preventative visit?

Wider issues: I saw a news article last week debating the idea of certain common over the counter painkillers possibly moving to script based because they have sometimes been featured in a teenage overdose. Imagine the strain on an already struggling system if everyone needed a script for Panadol. A clear case of hoping the decision-makers ensure that the cure isn't worse than the problem.

On another note, I am aware that some employers insist on a sick leave certificate if an employee has more than 1 day off work. This can't be helping at all. Let the malingerers malinger if we must, but don't fill doctors surgeries with patients who just needed one more day in bed.

Hope this didn't raise too many eyebrows, but we know that big problems almost never have just one cause and just one solution.

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Templates

The following new or updated templates are available at my website here:

- CVC Care Plan Gold Card (MD version)
- Cortisone Injection Consent Form
- Tasmanian Lung Service Request form at PHT website here. **

** *Updated by me, these should be available at the PHT site very shortly. The new ones have Dec 2022 in the footer. If you use the Tasmanian Lung Service you should make a point of grabbing the new forms and deleting any old versions in your software, as the* ***available tests have changed****.*

eReferral

Please update your address books with the following changes, remembering my full list can always be found here.

Dr Sutharshan Kannuthurai Gastroenterology Calvary Consulting Suites *chctlvcs*

BP/MD

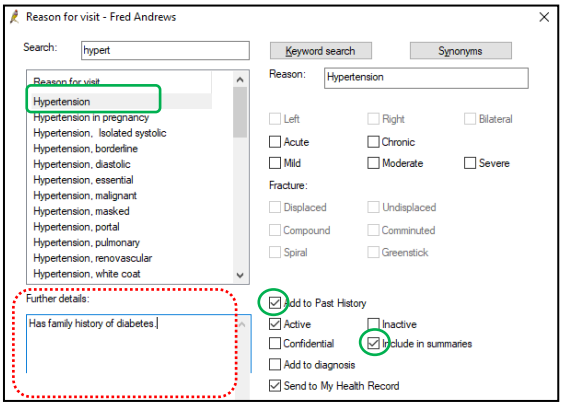
At a local practice the other day, I witnessed an experienced GP telling a younger GP that medical histories should be *dense*. I wasn't sure what she meant at first, but I didn't feel too bad as clearly she hasn't always understood me completely based on our training and support interactions over the years.

But what she was referring to was good, namely the practice of adding a coded item to the medical history list AND supplementing that entry with some free-text extra information or context using the dialogue box provided. On your screen this information sits alongside the diagnosis in the patient's medical history (BP) or ridiculously in a small box at the foot of the screen once you have selected the diagnosis (MD).

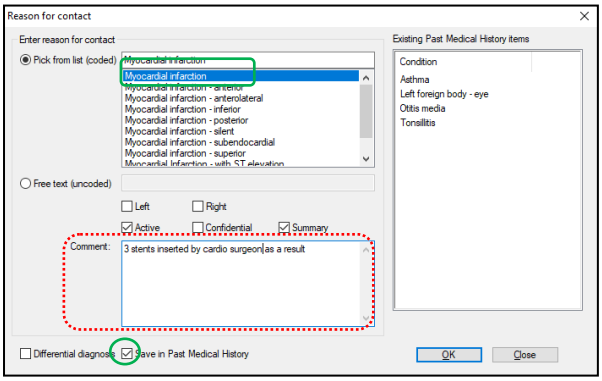
In either program though, it can incredibly usefully be shown on referral letters, health summaries and Shared Health Summaries. So you benefit from the coded entry in that disease/medication interaction checking takes place, whilst others especially benefit from the added tag-line of information that you as a GP see as both pertinent and important.

In either program, the dialogue box becomes enabled when you have indicated that you want to add your diagnosis or Reason for Visit to the patient's medical history.

BP



MD



In Best Practice, your referral letters will contain this detail if the Past Medical History is set up to auto-populate the letter. If your template presents you with a history selection screen, ensure you check the "Include Details" checkbox at the top of the selection dialogue. Your *Smartform* referrals and *Shared Health Summary* uploads will automatically include the detail.

In Medical Director, if the extra information does not show on your referral letters, get someone to edit the template. They need to go to *Clinical Details:History List* and right-click, selecting *Properties*. From here, check the *Include comments?* checkbox and save the changes. Actually doing that to all templates that include the patient's medical history would be good. As in BP, *Smartform* referrals and *Shared Health Summaries* will automatically include the detail.

So there it is, a really good way to make the Past History summary and generated documentation even more useful.

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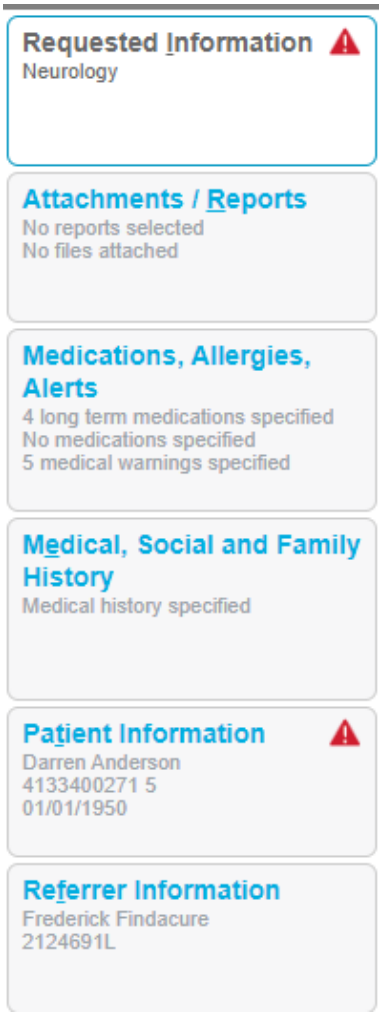
BP/MD

As mentioned on page 1, the addition of 30 new referral destinations at the LGH provides a good excuse to revisit this method and provide some tips for usage. Once you have clicked the HL icon, you are taken to the *Smartforms* menu.

Whilst THS clinics are the focus here, don't forget that using the top selection you can do an ereferral to quite a few private specialists using a very similar template. Similarly with the *My Aged Care Referral* option. Once you have selected your clinic, click on the handily located green *Continue* button at the extreme right of the screen. Your template will load.



Won't tell you how to answer the obvious questions the form asks you, but note the handy links to Tasmanian Health Pathways for the medical issue in question, as well as links to contact information for the clinic being referred to.
Use the *Browse for Consultation notes* button to import any consult notes you wish to include.

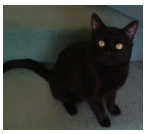
Great to be able to attach many document formats. Default selection choice is correspondence sent or received over the past 9 months. To attach something older, use the *Browse for Patient Document* button. If you are an MD user, possibly make a note of the date of documents you want to attach beforehand, as MD labels things unhelpfully. Document preview icon at far right of screen.

Auto-populates the patient's current Long Term medications. If you want to include a Short Term medication search and select it using the *Browse for More Medications* button. Note that here (and all through the template) you can click in the *Comments* area and free text other information.

Auto populates, with Current Medical History = Active Medical History and Relevant Past History = Inactive Medical History.
STILL doesn't pick up the dates of the history entries. Helpful referrers may want to generate and save a Patient Health Summary and attach it to the referral as this will show the dates.

Fully auto-populated information about the patient, with the ability to manually add next of kin.
For the purposes of this form, *Gender* seems to mean birth sex

I couldn't think of anything to write about this section, so here is a picture of my cat.



Through the form, compulsory fields have a red asterisk next to them and tabs that are missing compulsory information will show this symbol ⚠ If you don't have the compulsory information completed, you won't be able to *Preview* or *Submit* the form. Please remember to submit the form, I have seen more than one form around the traps that has been auto-saved but never submitted.

On that note, I recommend that practice admin teams monitor for unsent forms in the same way they monitor ereferrals that have actually been sent. In BP, it's *View..Healthlink Forms* from the main screen. In MD it's *Tools..Healthlink..Track Forms* from the front screen.

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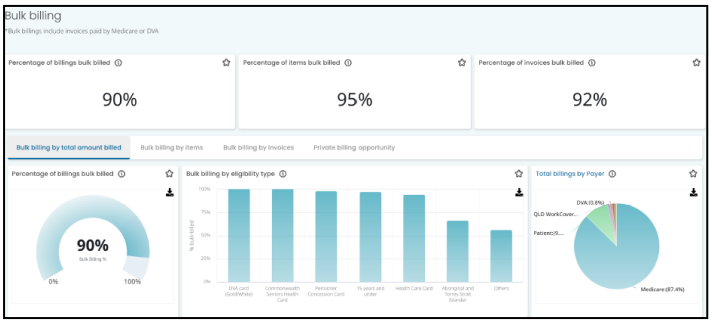
MD

So it appears Cubiko is coming to Medical Director. Best Practice users, especially those in corporate clinics will be used to this tool and the financial forensics it can collect about your practice. Not only collect, but display via a really slick and aesthetically pleasing dashboard type interface.



It can tell you so much more than I can cover in this article, with claims of over 1000 metrics. Delicious morsels like *Billings per Hour v Appointments per Hour* and *Diary wait time by hour and weekday*.

It also produces reports on what other item numbers todays patients may be eligible for. There is some overlap with PenCat as well in the area of chronic disease management opportunities etc, and unlike PenCat, Cubiko presents the information in real time rather than as an audit report. Nevertheless, I regard PenCat as predominantly clinical with Cubiko being predominantly financial.

I feel quite conflicted about this. The product has a really good reputation with people who use it really liking what it gives them. It's not much of a fit for the one Dr practice at Oatlands, but the bigger the practice or practice group the more useful weaponizing your data will be to running the business well or successfully. And if I was managing a big practice or practice group I would want this product on my desktop for the sheer joy of all the things it could tell me.

But personally it all leaves me a little cold, and I just can't get enthused. It feels like a further step away from actual patient care, and a concession that we are just all about the numbers. I know that statement may seem foolish and incredibly naïve, but there it is. I actually walk a little taller when I hear later that someone I have assisted or supported is a great doctor. Conversely, when a pm a couple of years ago told me that a GP was "a good little biller", I couldn't have been less inspired.

In somewhat typical fashion, right on the eve of the Cubiko/MD marriage, MD have released a "light" version called *Smart*, which is their own product accessible via Pracsoft. You can read about it here.

If you want to join the wait list for Cubiko installation with MD, there is information to be found here.

It's a really good product that can pretty much tell you anything you want to know about the financial performance of your doctors and practice as a whole. Just don't expect me to be excited about it.

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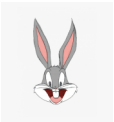
An Apology



In last month's newsletter, I somewhat carelessly stated that rabbits didn't pose much of a bite risk. Subsequently it was brought to my attention by multiple parties, that they or their patients had commonly suffered at the hands (actually teeth) of these carrot-munching ingrates.

I apologise for any misunderstanding or confusion caused by my article. By way of compensation, I've linked these useful guidelines to employ when bunnies attack.

In future I will resist the temptation to stray out of my lane and leave the David Attenborough stuff to, well, David Attenborough.

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